DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-31

2. STATE: MO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440-2.10

7. FEDERAL BUDGET IMPACT:
a. FFY _____ $_____
b. FFY _____ $_____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

3.1-A, page 15
3.1-A, page 16

9. PAGE NUMBER OF THE SUPERSEDES PLAN SECTION OR ATTACHMENT (If Applicable):

10. SUBJECT OF AMENDMENT:

The Department of Social Services previously submitted SPA 02-17, approved August 15, 2002, that eliminated optional dental coverage for adults, except for dentures and services related to treatment of trauma, effective July 1, 2002. On August 21, 2002, a Circuit Court judge in St. Louis County stopped DSS from implementing the reduction in the dental program. For the sake of clarity while DSS re-evaluates its position regarding adult dental services, we believe it is most appropriate to return the services of the adult dental program to those services that were covered on June 30, 2002.

11. GOVERNOR'S REVIEW (Check One)

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPE NAME:
Dana Katherine Martin

14. TITLE:
Director

15. DATE SUBMITTED: 12/20/02

16: RETURN TO: Missouri (02-31)
Approved: 01/30/03
effective: 10/01/02

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/23/02

18: DATE APPROVED:
JAN 30 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/02

20. SIGNATURE OF REGIONAL OFFICIAL:
James A. Scott, Acting

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid & Children's Health

23. REMARKS:
cc:
Renne
Vadner
Waite
CO
DSG-DIATA

SPA CONTROL
Date Submitted: 12/20/02
Date Received: 12/23/02

FORM HCFA-179 (07-92)

State Missouri

10. Dental Services

Dental services as medically indicated are covered for, but not limited to: restorations (limited to silicate cement, amalgam, acrylic or composite filling); extractions; surgical prophylaxis (limited to one in a six-month period); fixed permanent crowns (limited to resin, stainless steel for all recipients; porcelain, high noble metal, noble metal limited to recipients under 21 years old with prior authorization); oral examinations (limited to three in a twelve-month period in a nursing home); and permanent full or partial dentures. Fluoride treatments are a covered service for all recipients. However, fluoride treatments for recipients age twenty-one (21) and over are limited to certain conditions. Date of service is date services are received or date of placement in case of dentures, full or partial.

All dentures, including full and partial, initial or replacement, require Prior Authorization be secured before the service is provided.

All full dentures and certain partial dentures are covered. Orthodontic services, specific tests, laboratory procedures, bridges and certain overdentures are covered services only for recipients under 21 years old when prior authorized.

11.a.,b.,c. Physical Therapy and Related Services

Physical therapy, occupational therapy, and speech, language or hearing pathology or disorders are not provided and reimbursed as separate, independent practitioner services.

State Missouri

12.b. Dentures

All dentures, including full and partial, immediate or replacement, require Prior Authorization be secured before the service is provided.

Replacement dentures will be approved in cases where the dentures no longer fit properly due to significant weight loss as a result of illness or a loss of bone or tissue due to some form of neoplasm and/or surgical procedure. Dentures will also be approved when the dentures no longer fit or function properly due to normal wear and/or deterioration resulting from use over an extended period of time.

A denture reline is covered during the 12 month period following the immediate placement of dentures. When necessary, another reline is covered after twelve (12) months following the placement of immediate dentures. Denture relines and denture rebases are not covered within twelve (12) months of placement of replacement dentures. Denture reline and denture rebase are further limited to once within three (3) years of the date of the last preceding reline or rebase.

12.c. Prosthetic Devices

Prosthetic and orthotic devices, non-sterile ostomy supplies, oxygen, respiratory equipment, wheelchairs, hospital beds, Home Parenteral Nutrition and related supplies, and medically necessary items of miscellaneous durable medical equipment are covered and provided through the Missouri Medicaid Durable Medical Equipment Program.

Prior authorization is required for certain orthotic and prosthetic devices, as well as the purchase and/or rental of all HPN services, electric wheelchairs, custom wheelchairs, electric hospital beds and back-up ventilators.

An Oxygen and Respiratory Equipment Medical Justification (OREMJ) form is required for the purchase and/or rental of most oxygen and respiratory equipment services.

A Medical Necessity form is required for the majority of orthotic and prosthetic devices. The form is also required for all wheelchairs other than electric or custom, manual hospital beds, and miscellaneous items of durable medical equipment such as walkers, crutches and commodes.

Hearing aids and related services are covered through the Hearing Aid Program. Prior to the dispensing of an aid, all recipients are required to have a medical ear examination for pathology or disease by a physician to determine if the recipient is a candidate for an aid. Hearing aids and related testing procedures are limited to one series every four (4) years. However, exceptions may be made if prior authorized for the following: